



# GENESIS Accountable Care Organization

The **Genesis Accountable Care Organization (GACO)** network consists of over 100 Primary Care Providers and is supported by the NCQA-scored medical homes, which was put into place during 2011-2013. Existing referrals patterns to specialists have been left intact. Our care guidelines span the continuum of care, specifying care processes and metrics for physician office, home health, skilled care facilities, in-patient hospital, and emergency room.

Our ACO governance Board is 75% physician, and includes a community member. Beside the ACO Board, there are three physician-led committees that report to the Board: Finance and Contracting, Medical Management and Data, and Care Design.

## INSURANCE CONTRACTS:

- Medicare (17,000 lives)
- Wellmark (7,000)
- United Health Care (2,500)
- Genesis Employee Health Plan (8,900)

## Percent of savings to ACO from Insurance Contracts:

- Medicare 50%
- Wellmark 70%
- United 60%

## COST SAVINGS

- GACO has already received incentive payments from two of our commercial insurance partners.
- GACO has established a distribution methodology that routes dollars to offset the cost of care coordination staff, as well as going to participating providers.

**SCORECARDS:** Calculated at ACO level, clinic level, and provider level. The scorecards are distributed quarterly and the second set was just released.

## STRATEGIES

The Triple Aim informs our:

- Care guidelines ■ Processes
- Choice of participating providers
- Measures and incentive payment plan

## QUALITY MEASURES & GUIDELINES

- Transitions of care
- Cost of care
- Preventive services (cancer screening, immunizations, well exams)
- Diabetes
- Heart failure
- COPD
- Hypertension
- Asthma
- Pneumonia
- ADHD
- Migraine



## MEDICAL HOME

- 30 health coaches and navigators
- Provide self-management support using behavioral-based techniques to patients with chronic diseases
- Manage transitions of patients seen in ERs or discharged from hospital

**TRIPLE AIM:** Improved Health, Improved Patient Experience, Lower Total Cost of Care

## COMMUNITY INTEGRATION

- Our ACO nurse and program managers have met with community-based organizations, beginning a dialogue to find better ways to coordinate care.
- We are currently reviewing software that will allow qualified community-based professionals to view and make entries on patients.
- GACO has just partnered with a very large FQHC (Community Health Care) to broaden and deepen our ability to care for vulnerable populations.
- GACO is also partnering with other health systems across the state to create a clinical network to move patients seamlessly from PCP, to specialist, to university-level care.
- Genesis has embarked on a broad-based program of inventorying the community's health needs, and is working with community-based partners to address them.

## LESSONS LEARNED AND SOLUTIONS:

- Genesis is building its own health information exchange to link physician EMRs.
- The clinical scorecards are another way to show physicians that "clinical integration" is a powerful tool to improve care at the population level.
- GACO's physician participation model is flexible, allowing employed and independent physicians to integrate.

## CARE MODELS

- Practice guidelines for prevalent conditions, prevention and screening with built-in quality measures and tools

### WEIGHT LOSS AND EXERCISE EDUCATE AND REINFORCE ALWAYS

**PATIENT'S A1C < 7.5**      **PATIENT'S A1C ≥ 7.5**

INITIALLY

**TRIAL OF WEIGHT LOSS AND EXERCISE ONLY**

3 MONTHS

**SINGLE DRUG THERAPY**  
METFORMIN

3 MONTHS

**TWO DRUG THERAPY**  
METFORMIN + SULFONUREA OR TZD OR DPP-4 INHIB OR GLP-1 AGONIST OR BASAL INSULIN

3-6 MONTHS

**THREE DRUG THERAPY**  
METFORMIN + SULFONUREA OR TZD OR DPP-4 INHIB OR GLP-1 AGONIST OR BASAL INSULIN

**3RD DRUG IN DIFFERENT CLASS FROM LIST ABOVE**

3 MONTHS

**MULTIPLE INSULIN DOSE REGIMEN**  
BASAL + MEALTIME INSULIN DOSES + CORRECTION DOSES

### CARE MODEL: DIABETES, TYPE 2

**PATIENT PROMISE**  
For our diabetic patients, we will...

- Review the patient's health at a physician visit at least twice a year
- Measure BP at least twice a year
- Measure LDL-C at least yearly
- Measure A1c at least yearly
- Check urine for albumin yearly (unless kidney disease is already known to exist)
- Refer for retinal exam yearly
- Perform a foot exam yearly
- Ask about smoking; offer help to quit

hypoglycemia, limited life expectancy, advanced complications, extensive comorbidities, and when target is difficult to attain despite repeated education and insulin regimen.

- Patients should be seen by provider at least 2x/yr
- A1c should be done every 3 mo until at goal, then 2x/yr
- Patient factors, cost of drugs, side effects should drive choice of treatment option.
- Metformin is the first line drug, and...

| CLASS   | DRUGS   | ADVANTAGES   | DISADVANTAGES/COMMENTS  | COST   |
|---|---|--|---|--------|
| <b>Biguanides</b><br>↓ glucose production in liver<br>↑ insulin secretion | Metformin   | Low risk of weight gain; low risk of hypoglycemia; lowers risk of bad CV outcomes  | GI side effects are common; use with caution in CHF, renal insufficiency, hypoxemia, dehydration  | \$     |
| <b>Sulfonureas (2nd Generation)</b><br>↑ insulin secretion                | Glyburide<br>Glipizide<br>Glimeperide   | Well tolerated; lowers risk of microvascular complications                         | Increased risk of hypoglycemia, especially in older patients; weight gain; loss of effectiveness over time  | \$     |
| <b>Meglitinides</b><br>↑ insulin secretion                                | Repaglinide<br>Nateglinide  | Blunts glucose rise when taken at mealtime   | Increases risk of hypoglycemia, weight gain; multiple dosing is inconvenient  | \$\$\$ |
| <b>Thiazolidinediones (TZD)</b><br>↑ insulin sensitivity                  | Pioglitazone  | No hypoglycemia; remains effective; ↓ LDL-C, TG; decreases risk of bad CV outcomes | Weight gain; increases risk of new onset CHF, edema; ↑ LDL-C; increases risk of fracture in predisposed patients; possible increase risk of bladder cancer  | \$\$\$ |
| <b>DPP-4 Inhibitors</b><br>↑ insulin secretion, ↓ glucagon secretion      | Sitagliptin (Januvia)<br>Linagliptin (Trasylor)<br>Saxagliptin (Onglyza)  | Relatively low risk of hypoglycemia; weight neutral                                | Pancreatitis rarely; urticaria  | \$\$\$ |
| <b>Non-insulin Injectables</b>  | Incretin Mimetics (GLP-1 Agonists)<br>Exenatide (Byetta)<br>Exenatide, extended (Bydureon)<br>Liraglutide (Victoza)<br>Amylin Analog (Pramlintide (Symlin)) | All induce weight loss; GLP-1 agonists may improve beta cell mass/function         | Exenatide and liraglutide are contraindicated in patients with medullary thyroid cancer.<br>• Exenatide: peaks at 2 hr, lasts 10 hrs<br>• Exenatide, extended: lasts one week<br>• Liraglutide: peaks at 8-12 hrs, lasts 24 hrs<br>• Pramlintide: lasts 4 hrs | \$\$\$ |
| <b>Long Acting Insulins</b>   | Glargine (Lantus)<br>Detemir (Levemir)  | Basal Insulin, injected once daily   | Disadvantage: weight gain; Onset at 3-6 hrs, lasts 24 hrs   | \$     |
| <b>Intermediate Acting Insulins</b>                                       | NPH human (Humulin)<br>N, Novolin N   | Basal insulin, injected once or twice daily  | Disadvantage: weight gain; Onset at 1-2 hrs, peak at 6-12, lasts 18-24 hrs  | \$     |
| <b>Rapid Acting Insulins</b>  | Lispro (Humalog)<br>Aspart (Novolog)<br>Glulisine (Apidra)  | Injected at mealtime   | Disadvantage: weight gain; Onset 30 min, peak effect 1 hr   | \$\$   |

**TITRATION OF METFORMIN**

- Encourage patient to accept minor GI symptoms because the drug is so effective.
- Begin with 500 mg once or twice daily at breakfast and supper, or 850 mg once daily.
- After 5-7 days, if no GI symptoms, advance to one 850 mg tab, or two 500 mg tabs, twice daily.
- If GI symptoms appear, reduce dose and advance at a later time.
- Maximum effective dose is 1000 mg twice daily, but 850 twice daily may be adequate.

**INSULIN DOSING TIPS**

- Start with 0.1-0.2 units/kg of long or intermediate acting insulin at bedtime.
- Adjust 5-10% daily until fasting glucose is <140.
- Give 1/3 of basal dose as rapid acting insulin at largest meal, reducing basal dose by same amount.
- Add rapid acting insulin at second meal if necessary, using same approach.

**REFER TO ENDOCRINOLOGY WHEN...**

- Consider referral to Diabetes Care Center first.
- Patient is not at goal for BP, LDL-C, or A1c after 1 year.
- Patient is making no progress after 6 months.
- Patient is having frequent hypoglycemic episodes.

EVIDENCE: ADA: "Standards of Medical Care in Diabetes 2013"; AACE | EXPERT: C Waideman MD | EDITOR: W Langley MD  
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